12100 Valley Blvd. Ste. 109A
El Monte, CA 91732

8825 Whittier Blvd.
Pico Rivera, CA 90660

14550 Haynes Street
Van Nuys, CA 91411

SLIDING FEE APPLICATION

NAME: _____ **DOB:** _____ **MRN #:** _____

Sliding Fee Discount Program and Eligibility

The Sliding Fee Discount Program is a federal program that permits Southern California Medical Center to discount normal charges for all services provided within SMC's scope of project. **Eligibility** is based on **income and family size only**. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons **at the earlier of thirty (30) days from the date of the first visit, or if a second visit occurs, before the thirty days at such date**. If documentation is not provided within the 30 days for date of service, the patient will be considered to be 100% self-pay. You must report any changes in family income or number of members in the household when these changes occur. Information must be updated every twelve (12) months or with any change of household income or household size. Falsification of this information will result in forfeiture of Sliding Fee Scale privileges and possible release from the practice as it is a violation of Federal Law. See SCMC's Sliding Fee Discount Program Policy for full details of acceptable forms of proof of income and family size.

(Please fill out the form, sign and Provide Proof of Income)

Eligibility Determination

TO BE COMPLETED BY PATIENT/GUARDIAN: Please complete ALL your family information below:

Name	Family Relation	Date of Birth	ID Number (SSN, DL, etc.)	Income	Frequency W/B/M/Y	Proof of Income Documentation * (1-5)	For Internal Use, Only: Date All Documentation Received	For Internal Use, Only: Documentation Received By

*****Documentation must be provided by patient or guardian to determine eligibility for Sliding Fee Scale*****

I understand that the information I provide on this form is subject to verification by Southern California Medical Center. I certify that the above information is true and correct to the best of my knowledge and that I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

Patient/Guardian Signature **Printed Name** **Date**

***Proof of Income:** Proof of Income documentation to determine eligibility will require the patient to provide one of the following:

1) Most current tax returns modified adjusted gross income (MAGI) amount,
2) Last payroll check stub (gross income),
3) Social security earnings (or other retirement or VA benefits), including unemployment and child support, court orders, welfare checks, workman's compensation checks, etc.
4) Letter from Employer may be accepted as proof of income if a patient does not file income tax returns and does not get paid with a check,
5) Self declaration (The patient may self-declare his/her income for the initial visit each year if proof of income is unavailable. However, proof of income is required for subsequent visits.)

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NAME: _____ **DOB:** _____ **MRN #:** _____

…… (DO NOT write below this line. To be completed by SCMC.) ……

Acceptable Income Documentation [Enter (√) if verified and obtained]		Calculated Amount Associated with Documentation
	1) Most Current Federal Tax return.	
	2) Paycheck stubs (Gross Income) If hours worked and amounts vary an average will be taken for the month)	
	3) Company letter stating annual earnings (Letter must contain a contact person and phone number for contact. -Should be verified by the SCMC Representative.	
	4) Official Letters / Documents from Social Security, Courts, Child Support, VA payment, unemployment payments, welfare checks, workman's compensation checks, etc.	
	5) Self-Declaration (The patient may self-declare his/her income for the initial visit each year if proof of income is unavailable. However, proof of income is required for subsequent visits.)	
Total Income Amount		

Total Number of Family Members Applying for the Sliding Fee Program	

Enter (√) if verified and obtained	Verified and Obtained Information
	Acceptable identification for each family member listed on Sliding Fee Program Application.
	All family member('s) name(s) and date(s) of birth listed on Sliding Fee Program Application.

Poverty Service Class (A) (B) (C) (D) (E)	Medical Slide Nominal / Flat Fee	Dental Slide Nominal / Flat Fee	Slide Effective Date	Slide Termination Date

Signature of SCMC Staff **Printed Name** **Date**

Signature of Supervisor (Required when EE is under training or for QI purposes) **Printed Name** **Date**